DPH Date Rec'd (stamp)

MULTI-BOARD COMPLAINT FORM

DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HEALTH PROFESSIONS LICENSURE
OFFICE OF PUBLIC PROTECTION
TEL (617) 973 – 0865 FAX (617) 973-0985 TTY (617) 973-0895
http://www.mass.gov/dph/boards/

DPH USE ONLY:
Entered into Database (date) _____/_ _____/_____ Docket # _____ - _____ - _____ Initials _____

Please complete this form as fully as possible. Please TYPE or WRITE LEGIBLY in ink.

COMPLAINANT

☐Mr.
☐Mrs.
☐Ms. _____ _____ _____ _____
Your Last Name | Your First Name | Patient's Full Name (if different) | Patient's Age

Your Business Name: _____
(If applicable)
Business Address: _____ _____ _____
Street | City | Zip

Your Address: _____ _____ _____
Street | City | Zip

Patient's Address (if different) _____

Your Primary Phone number: ( )
Your Secondary Phone number : ( )
Your Email:

LICENSEE

☐ RESPIRATORY THERAPIST ☐ NURSING HOME ADMINISTRATOR ☐ PHYSICIAN ASSISTANT
☐ GENETIC COUNSELOR ☐ PERFUSIONIST

_____ _____ _____
Last Name | First Name | Lic # (if known)

Licensee's Business Name:_____ Phone #:_____

Business Address: _____ _____ _____
Street | City | Zip

COMPLAINT DESCRIPTION

NATURE OF COMPLAINT

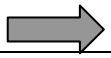
☐ Medication error ☐ Impairment ☐ Practice beyond the scope of practice
☐ Patient abandonment/neglect ☐ Unlicensed practice ☐ Drug diversion
☐ Quality of care provided ☐ Fraud ☐ Criminal conviction/conduct
☐ Other (specify)

DATE(S) OF INCIDENT(S): _____

DETAILS OF COMPLAINT Clearly describe the incidents leading up to your complaint. If applicable, **attach copies** of documents such as witness statements, medical records, copies of prescriptions, photographs, etc. that support your statements. DO NOT SEND ORIGINALS. Attach extra paper as needed to complete this section.

_____
_____
_____
_____
_____

Continue on next page if needed



DESCRIPTION CON'T

Details of complaint (continued)_____

_____

_____

_____

_____

_____

COMPLAINT DETAILS

Have you discussed this matter with the licensee, the licensee's office or facility? ☐ yes ☐ no

If yes, name and phone number of person contacted: _____

Date of contact: _____ How was contact made? (phone, e-mail, letter, in person) _____

Result of contact: _____

_____

_____

Witness name(s) and telephone number(s) (if applicable)_____

Have you filed this complaint with any other state or federal agencies? _____ If yes, identify and explain

_____

_____

If this complaint is against a person licensed by Boards of Nursing Home Administrators, Physician Assistants, Respiratory Care, Perfusionists, or Genetic Counselors, **are you willing to testify** regarding this matter at a formal hearing?
☐ Yes, I am willing. ☐ No, I am not willing.

AUTHORIZATION FOR RELEASE OF RECORDS AND REFERRAL OF COMPLAINT

My signature on this form, or photocopy thereof, authorizes the Department of Public Health to:
(1) receive copies of all my medical, dental, and mental health records relating to my complaint, and (
2) refer my complaint to other law enforcement authorities for appropriate action.

I understand that all complaints are investigated to determine their factual basis. The act of filing a complaint and its receipt and/or investigation by DPH does not mean that disciplinary action will be taken against the licensee.

I hereby declare that I am at least 18 years old and affirm under penalties of perjury that the information provided in connection with the foregoing complaint is true and correct to the best of my knowledge, information and belief.

_____ _____

Signature of **Date**

☐ **Patient or**
☐ **Legal Representative** (attach documentation), **or**
☐ **Other Complainant**

Mail this form to:
Department of Public Health
DHPL Office of Public Protection
239 Causeway Street, 4th Floor
Boston, MA 02114